Testimony of Lance Q. Johnson, AARP Volunteer
Before the Joint Committee on Aging
February 10, 2011

Good morning Chairwoman Prague, Chairman Serra, ranking members Kelly & Frey, and members of the Committee on Aging. My name is Lance Q. Johnson and I am AARP's volunteer leader for health and supportive services. AARP is a nonprofit, non-partisan organization with nearly 600,000 Connecticut members. AARP helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole.

On behalf of AARP members in Connecticut, I want to express AARP's support for:

- **H.B. 6155,** *AA Reducing the Individual Contribution under the State-Funded Home-Care Program for the Elderly*
- **S.B. No. 774,** *AA Increasing Eligibility for the Alzheimer's Respite Care Program*
- **S.B. No. 775,** *AA Increasing Eligibility for the Connecticut Home-Care Program for the Elderly*

AARP Strongly Supports Reduction of the Co-Pay on Elders on the State-Funded Home-Care Program

H.B. 6155 would reduce the co-pay on services for individuals on the state-funded home care program by 2%. AARP has advocated for elimination, or reduction, of the co-pay because the additional co-pay has directly resulted in seniors dropping off the program and the method for calculating the co-pay places the heaviest burden on those clients most at risk of entering a nursing facility. Despite a significant reduction in the co-pay last year,[1] DSS reports that approximately 500 seniors have been forced off the program and 17 of those seniors are now in a nursing facility receiving care.

Also, the method used to calculate the co-pay is especially harsh on those individuals closest to nursing home eligibility. The reason is because the co-pay is not calculated based on income or ability to pay, but instead based on the cost of an individual's care plan. Those individuals with the highest level of need are asked to pay the highest co-pays.

AARP supports elimination, or at least, a further reduction of the co-pay. We urge committee members to look at new opportunities in the federal Affordable Care Act to maximize federal funding for the Connecticut Home Care program, which in turn will allow us to reduce the co-pay without costing the state money. The federal Affordable Care Act[2] gives states additional flexibility to cover home care services through Medicaid, without requiring that those individuals meet

[1] Connecticut Public Act 10-179 § 21.

[2] Patient Protection and Affordable Care Act, P.L. 111-148, enacted March 23, 2010, together with the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted March 30, 2010.

nursing home level of care. This means that Connecticut can now cover individuals, who are income and asset qualified, but not currently functionally qualified for the Elder Waiver. By covering additional state-funded individuals under Medicaid, Connecticut could eliminate the co-pay for those individuals plus bring in additional federal funding through a Medicaid match. The additional federal funding could be used to strengthen the program for individuals, who remain on the state-funded program.

Moreover, by transferring state-funded clients to Medicaid, Connecticut is better positioned to qualify for the federal Balance Incentive Payment Program (BIPP), which provides an enhanced FMAP of 2% if a state balances its Medicaid LTC funding, so that at least 50% of Connecticut's Medicaid long-term care funding is spent on home and community based care after a 5-year period. Based on estimates done by AARP consultants, Connecticut would receive an additional $34 million in federal funding by participating in the BIPP program. This money could also be reinvested into the long-term care system and help support state-funded programs like the Connecticut Home Care Program and the Alzheimer's Respite Care program.

AARP Also Supports Expanded Eligibility of the Alzheimer's Respite Care Program & the Connecticut Home-Care Program, Provided This Does Not Impact the Ability of Current Enrollees to Get Services or Supports (S.B. 774 & S.B. 775)

AARP supports increasing the eligibility for both the Alzheimer's Respite Care program and the Connecticut Home-Care Program for Elders. S.B. 774 would expand eligibility by increasing the income level for the Alzheimer's Respite Care program to $50,000 annually. Similarly, S.B. 775 expands eligibility for the state-funded Connecticut Home-Care Program by raising the asset limits. Allowing individuals to keep more of their assets is important to helping them remain in the community and be able to afford the unexpected costs that arise in the community.

Both the Alzheimer's Respite Care and Connecticut Home-Care programs have been major budget priorities for AARP since their inception. While AARP would support increasing the eligibility of the programs, we do not believe that it should be at the expense of capping the programs or creating waiting lists for services. During the 2010 budget session, when Governor Rell closed the Alzheimer's Respite Care program, AARP fought alongside many champions on this Committee to get the program reopened. Additionally, we fought to make sure that any changes to the Connecticut Home-Care Program for Elders did not include a cap on enrollment. We believe that expanded eligibility must come with increased funding to ensure that the newly eligible individuals are actually able to access services and supports, not just get on a waitlist.

It is essential that policy makers explore options to increasing eligibility to these critical home and community based care programs by maximizing federal funding opportunities included in the federal Affordable Care Act. AARP hopes to work with members of this Committee to identify those funding opportunities. We have attached an AARP policy brief outlining some of those opportunities. We look forward to working with you this session. Thank you.

Fact Sheet

Health Care Reform Improves Access to Medicaid Home and Community-Based Services

Health care reform legislation recently signed into law will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This fact sheet looks specifically at parts of the new law that provide new financial incentives for states, and creates opportunities within existing programs, to promote Medicaid home and community-based services (HCBS) for older persons and adults with disabilities.

Health Care Reform Provides HCBS Balancing Options and Incentives

The majority of older persons and adults with disabilities say that they prefer to remain in their home and community. Despite this preference, Medicaid—the primary payer for long-term services and supports (LTSS)—spends more of its long-term care (LTC) dollars on institutional services than on home and community-based services (HCBS). Many states, however, have been moving toward a more balanced mix of institutional and HCBS, although the pace of change varies quite substantially across states.

The new health care reform law provides opportunities for states to improve the balance between institutional and HCBS, even in the current tight fiscal environment. It does so in two broad ways. First, the bill creates two new Medicaid initiatives that offer financial incentives to states to improve access to HCBS. Second, it modifies existing Medicaid and other provisions to facilitate and extend opportunities for older persons and adults with disabilities to receive HCBS.

The number and variety of new options, combined with the prospect of additional federal funds, may give some states added flexibility in balancing their LTC system. In some circumstances, however, states must maintain certain HCBS spending levels or eligibility requirements in order to qualify for the additional federal funds. Maintaining current funding or eligibility levels may present a challenge to some cash-strapped states.

New Programs

The legislation creates two financial initiatives:

- The Community First Choice option
- The State Balancing Incentive Payments Program

Community First Choice (CFC) Option

The CFC option is a new Medicaid state plan option that covers HCBS attendant services and supports to Medicaid-eligible individuals with institutional level of care need. States that take up this option will receive an increase in their federal Medical Assistance Percentage (FMAP) of 6 percentage points for expenditures related to the option. The option begins in October 2011.

Requirements of the Option

States must meet a number of requirements under the option.

First, states must maintain or exceed HCBS expenditures for older persons and adults with disabilities in the first full fiscal year the option is implemented.[1]

Second, states must offer services statewide and may not impose waiting lists or other enrollment restrictions on eligible individuals.

Third, states must provide certain HCBS attendant services and supports. These services and supports must be based on a person-centered plan of service and under an agency-provider or other model, in which attendant services are managed and controlled to the maximum extent possible by the recipient or recipient's representative.

Covered services must include assistance in accomplishing and the acquisition, maintenance, and enhancement of skills to accomplish activities of daily living, instrumental activities of daily living, and health-related tasks. Services must also include back-up systems for continuity of services and supports and voluntary training on the selection and management of attendants.

States may also choose to cover the cost of transitioning from an institution to the community, or services that increase independence and substitute for human assistance. The option would not cover room and board costs, home modifications, medical supplies, and other specified services.

Other requirements include establishing and maintaining a comprehensive, continuous quality assurance system, and establishing a Development and Implementation Council, a majority of whose members are individuals with disabilities, older adults, and their representatives.

Who Can Qualify?

States have some flexibility to set income eligibility levels under the option.

States may choose an income level up to 150 percent of the federal poverty level (FPL). Alternatively, a state may choose a higher income level if, under the State plan, a higher level applies for persons who require institutional level of care to be eligible for Medicaid services.

Consequently, states may enroll individuals up to their state's Special Income Limit, which may be 300 percent of the Supplemental Security Income (SSI) benefit amount in some states, or through the medically needy program.

State Balancing Incentive Payments Program

The Balancing Incentive Payments Program provides a five-year grant to states that spent less than 50 percent of their Medicaid LTC dollars on non-institutional services and supports. Funding will be available from October 1, 2011, to September 30, 2015.

The grant amount will vary depending on the state's balance of spending between institutional and non-institutional services.

Qualified states that spent less than 25 percent of their total 2009 Medicaid LTC dollars on HCBS will be eligible for an enhanced FMAP of 5 percentage points. Qualified states that spent at least 25 percent but less than 50 percent of their total 2009 Medicaid LTC dollars on HCBS will be eligible for an enhanced FMAP of 2 percentage points.

The statute gives the Secretary of Health and Human Services broad authority to establish definitions that may differ from those specified in the statute.

Definitions of qualifying states and qualifying expenditures for purposes of the grant could change and affect state

eligibility to participate in the program. The Secretary will be providing additional clarity as this provision is implemented.

Requirements of the Program

There are three main requirements for the grant.

First, states must implement structural changes to their Medicaid program that will expand and diversify non-institutional services. These changes must include the development of a statewide single entry point system ("No Wrong Door"), conflict-free case management services, and core standardized assessment instruments for eligibility determination.

These changes have to be in place within six months following the application for the grant. States must also collect certain data.

Second, states must commit to improve the balance of spending between HCBS and institutional services and meet targeted spending levels by October 1, 2015. States that have spent less than 25 percent of their total 2009 Medicaid LTC budget on HCBS must achieve a target of 25 percent by October 1, 2015. States that have spent at least 25 percent but less than 50 percent of their total 2009 Medicaid LTC budget on HCBS must achieve a target of 50 percent by October 1, 2015.

Third, states must use the additional federal funds under this program for new or expanded Medicaid non-institutional services and supports. In addition, states must maintain eligibility standards, procedures, or methodologies that were in place on December 31, 2010.[2]

Who Can Qualify?

States may expand coverage under the program to Medicaid recipients who qualify through existing eligibility pathways. For instance, states could expand through waiver services, Personal Care Services, or through the Medicaid HCBS state plan amendment option (as described below).

If the state chooses to expand coverage through the Medicaid HCBS state plan amendment option, the state may establish a higher income eligibility level than currently offered under the state plan amendment. States may enroll individuals whose income is up to 300 percent of SSI (rather than the current 150 percent of FPL).

States choosing this option also may enroll individuals using less stringent needs-based eligibility criteria than those used for institutional services. This is a requirement of the Medicaid state plan amendment option for HCBS.

Modifications to Existing Programs

The new legislation also improves access to HCBS by doing the following:

- Modifying the existing 1915(i) Medicaid state plan amendment option for HCBS to enable states to extend full Medicaid benefits to HCBS participants through the state plan amendment. States are given added flexibility in the type, scope, and duration of services they may offer, as well as the ability to target services to specific populations. States are also given the flexibility to offer expanded services, subject to approval from the Centers of Medicare and Medicaid Services. States must provide services statewide and may not place caps on enrollment.
- Extending funding and authority for Aging and Disability Resource Centers (ADRCs), which are one-stop, single-entry access to LTSS administered by the Administration on Aging. ADRCs are authorized and funded for an additional five years at $10 million each year from 2010 to 2014.

- Extending funding and authority for the Money Follows the Person (MFP) Rebalancing Demonstration program. MFP enables available funds to move with the person to the most appropriate and preferred setting. MFP is authorized and funded for an additional five years at $450 million each year from 2012 to 2016.

  The new legislation also reduces the eligibility requirement for MFP from a minimum stay of six months to a stay of 90 consecutive days in a nursing home. Nursing home days solely for short-term rehabilitation will not count toward the 90-day minimum required stay.

- Requiring states to extend income and asset protections for spouses of Medicaid HCBS recipients so that a spouse of a disabled person is not forced to spend all of the couple's resources to Medicaid eligibility levels so that the disabled spouse can qualify for Medicaid (also known as spousal impoverishment protection). Currently, states are required to extend spousal impoverishment protections only to Medicaid recipients in nursing homes. States have the option but are not required to extend these protections to spouses of HCBS recipients. This new provision begins in 2014 and expires after five years.

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[1] Specifically, the legislation requires maintaining or exceeding expenditures under Sections 1905(a), 1915, and 1115.

[2] States receiving Medicaid fiscal relief under the American Recovery and Reinvestment Act (ARRA) of 2009 are required to maintain the same Medicaid eligibility requirements that were in effect on July 1, 2008. The ARRA Medicaid maintenance of eligibility requirement extends until December 31, 2010. Thus, the maintenance of eligibility requirement under the Balancing Incentive Program requires states to apply eligibility standards that were in effect on July 1, 2008.

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